1992

Health care industry developments - 1992; Audit risk alerts

American Institute of Certified Public Accountants. Auditing Standards Division

AUDIT RISK ALERTS

Health Care Industry Developments—1992

Update to AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services*

AICPA
American Institute of Certified Public Accountants

NOTICE TO READERS

This audit risk alert is intended to provide auditors of financial statements of providers of health care services with an overview of recent economic, professional, and regulatory developments. It has not been approved, disapproved, or otherwise acted upon by a senior technical committee of the AICPA.

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Industry and Economic Developments

Continued economic uncertainty, greater governmental budget constraints, and rising operating costs have been some of the major forces intensifying the financial and economic pressures on the health care industry. The result of these factors has been a weakening of the financial condition for many health care providers.

Other trends that have contributed to the economic and financial hardships of the health care industry include—

- Alternate delivery systems—The shift away from inpatient use of hospitals to lower-cost service providers such as ambulatory, outpatient, community-based, home-based, and specialty providers continues to have significant impact on the industry's revenues.
- Changes in third-party payment methods—All providers are continuing to feel the negative effects of changes in payment methods that became common in the 1980s. More and more state Medicaid programs, Blue Cross plans, and other insurance plans are adopting prospective, per-case, per diem payment systems similar to those used by Medicare. In addition to the shift toward payment systems that place financial risk on the health care provider rather than on the recipient, payment rates are declining.
- State budgetary constraints—Most states are continuing to struggle with funding shortages as demand for health care services increases and funding mechanisms become restricted. Contributing to the problem this year was legislation that revamped the Medicaid provider tax by placing limits on the use of voluntary contributions and provider-specific taxes.

Other factors contributing to strained financial conditions include shortages of trained health care workers, increases in indigent and uninsured patients due to the downturn in the economy, and declining availability of capital. Continued financial difficulties may result from problems with providers' debt structures, Medicare and Medicaid payments, tax issues, labor relations, licensing and accreditation, and compliance with fraud and abuse rules.

Auditors of entities that provide health care services should consider these factors, as well as their clients' plans for and ability to deal with them, as they assess audit risk. Specific areas are discussed in more detail below.

Hospitals

Acute-care rural and inner-city hospitals are continuing to close as a result of their inability to cope with the changing financial environment. Conditions that may be indicative of increased audit risk in hospital audits include declining patient utilization, high concentrations of admissions among individual medical staff members or managed care plans, low profit margins, overstaffing, outdated facilities, high levels of uncompensated care, excess capacity, inadequate availability of qualified medical staff, and slow collection of accounts receivable.

In addition to reductions in third-party payment rates, many hospitals are encountering external "patient billing audit firms." These firms are hired by payors to audit bills they receive from hospitals to look for services not received and excessive charges. In addition, third-party administrators (TPAs), health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other third-party managed care organizations are pressuring hospitals for discounts, challenging utilization of services, and generally reducing the hospitals' ability to pass rate increases on to their customers. Auditors should be mindful of these factors when reviewing the collectibility of third-party receivables.

HMOs

The financial condition of many HMOs, unlike that of many other types of providers, has generally improved during the past few years. However, some HMOs continue to experience financial difficulties that may adversely affect their ability to pay hospitals for services rendered to HMO subscribers. In assessing audit risk relative to HMO clients, auditors should consider information regarding (1) state licensure requirements that relate to financial solvency (such as requirements to maintain a specified degree of liquidity or minimum surplus balances), (2) Medicare/Medicaid contract provisions regarding financial solvency, (3) state requirements for HMOs to fund insolvency pools, and (4) enrollment trends.

Industry Trend Data

A variety of publications pertaining to industry trends and statistics and offering profiles of hospitals and other health care entities are available. The Health Care Financial Management Association (which can be reached at 800-252-4362) publishes the annual *Healthcare Industry Almanac* (formerly titled *Financial Report of the Hospital Industry*), which summarizes trends in

the health care industry. The report is based on several financial indicators and is broken down by geographic region. Financial ratings of health care institutions that have issued publicly held debt may also be obtained from Standard & Poor's Ratings Information Department (212-208-1527), or Moody's Investor Service (212-553-0533). In addition, the American Hospital Association (800-242-2626) prepares the National Hospital Panel Survey Report service and the Hospital Statistics Report. Many states also have data-gathering departments within the state government or industry trade associations for HMOs, skilled nursing facilities, and hospitals.

Other sources of provider data include *The Comparative Performance of U.S. Hospitals: The Sourcebook* (available from Health Care Investment Analysts [HCIA], 800-568-3282); Group Health Association of America's (GHAA's) *HMO Industry Profile* (202-778-3247); and HCIA's *Guide to the Nursing Home Industry* (800-568-3282).

Regulatory and Legislative Developments

New Physician Payment System

Effective January 1, 1992, the Health Care Financing Administration (HCFA) implemented a major change in the method by which Medicare pays for physician services. This new system of payment, known as the resource-based relative value scale (RBRVS), is based on an abstract ranking of the value of physician procedures. Combined relative values assigned to each procedure recognize the resources necessary to render the service. The RBRVS is being phased in over four years and will be fully effective in 1996. Generally, primary care physicians receive increased reimbursement while specialists' compensation is reduced.

The changeover of the physician payment system to RBRVS will have implications for hospitals and other health care organizations as well. It may—

- Cause substantial increases or decreases in amounts of Medicare revenue collected by hospitals for physicians with income guarantees or salaried physicians.
- Prompt physicians to pressure hospitals for additional compensation for administrative duties.
- Necessitate revisions to coding and billing systems.
- Foster more intense competition between physicians and hospitals for outpatient services.

It also may affect the financial feasibility of existing or planned business arrangements between hospitals and their medical staffs. In assessing audit risk, auditors should consider these possibilities, as well as their clients' plans for dealing with them. Auditors should also evaluate any contractual

commitments with physicians, including investments in physician practices and in joint ventures with physicians, to consider whether there are any asset realization or disclosure issues (see also "Hospital-Physician Relationships").

Tax-Exempt Status Challenges

At the national level, both the Internal Revenue Service (IRS) and Congress have been scrutinizing the tax-exempt status of not-for-profit hospitals. At the same time, mounting budget deficits are causing some states and municipalities to view hospitals as an untapped source of property tax revenue. In general, there is a growing perception among policymakers and the public alike that the not-for-profit hospital sector needs to demonstrate why it deserves its tax-exempt status.

On March 27, 1992, the IRS released revised, highly detailed guidelines to be used by IRS auditors in examinations of not-for-profit hospitals to determine continued eligibility for tax-exempt status. The new guidelines provide specific examples of aspects of a hospital's organization that should be present, along with specific examples of practices or organizational structures that the IRS views as violations or suspect practices. These guidelines, which were reproduced in the Bureau of National Affairs' *Daily Tax Report* dated April 2, 1992, may be a useful reference tool for auditors of not-for-profit hospitals.

Hospital-Physician Relationships

Because physicians are able to significantly influence Medicare and Medicaid payments to hospitals through referrals and admissions, relationships between physicians and health care organizations that require hospitals to make payments to physicians for referrals have come under close governmental scrutiny.

The Medicare/Medicaid Anti-Fraud and Abuse statute prohibits misuse of Medicare or Medicaid funds to make kickback payments rewarding physicians for referrals and admissions. Because the law was drafted so broadly, many common commercial arrangements between hospitals and physicians are covered. The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) has issued a Management Advisory Report, *Financial Arrangements Between Hospitals and Hospital-Based Physicians*, that identifies potential violations of the anti-kickback statute. Along with others, the following common practices are cited as suggestive of potentially unlawful activities:

- Allowing use of free or significantly discounted office space or equipment in facilities close to the hospital
- Providing free or significantly discounted staff services such as nursing or billing

- Guaranteeing that a hospital will supplement a physician's income up to a certain amount
- Providing loan arrangements that are low-interest, interest-free, or that may be "forgiven" if referrals are made to the hospital

HHS rules also specify various payment practices (safe harbors) that are protected from criminal prosecution or civil sanctions.

The tax-exempt status of not-for-profit providers may also be jeopardized by certain hospital-physician arrangements. If a hospital pays a physician for services that are not performed, or if a joint venture yields benefits to a physician that outweigh the benefits to the hospital, the IRS may allege that private inurement has occurred. The OIG's safe harbors do not preempt provisions in the Internal Revenue Code that prohibit private inurement. Another publication of the OIG, *Fraud Alert on Joint Ventures,* identifies characteristics of joint-venture relationships that may cause the relationships to be questioned.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

In the last several years, states have attempted to increase the amount of Medicaid federal matching funds for which they are eligible by increasing the amount of medical assistance they provide. To provide funding for the increased medical assistance, they have either taxed providers or sought donations or other voluntary payments from providers.

In late 1991, Congress approved a compromise between HCFA and the states over such Medicaid financing arrangements. As a result, funding from provider donations is no longer eligible for federal matching funds. In general, funding from "broad-based" provider taxes will continue to be eligible for federal matching funds as long as the taxes are applied uniformly to all hospitals or physicians and to all their related businesses, and as long as no provision is included that would guarantee a return to the provider of the tax paid.

Auditors with clients affected by such arrangements should understand the substance of the state programs in which their clients are involved in order to determine the appropriate accounting for the transactions. Section 6400 of the AICPA's *Technical Practice Aids* includes questions and answers published by the AICPA's Technical Information Service that provide guidance in accounting for these types of funding arrangements.

Ambulatory Payment Rates

In the December 31, 1991 *Federal Register* (56 F.R. 67666), HCFA published a notice announcing additions to and deletions from the list of ambulatory

surgical center (ASC) procedures and payment groups. Litigation initiated to amend the notice caused delays in the scheduled December 31, 1991, implementation. As a result, fiscal intermediaries have been unable to process Medicare Part B ASC claims. Auditors should consider the impact of these delays as they evaluate the collectibility of accounts receivable.

Disproportionate Share Hospitals

The Omnibus Budget Reconciliation Act (OBRA) of 1989 and 1990 made changes affecting the way high disproportionate share hospitals are paid. Facilities are designated as having a high disproportionate share when their disproportionate share percentage, determined through application of a formula described in the Medicare regulation, exceeds 20.2 percent. Such facilities are scheduled to receive benefits from changes to the formula that will be effective October 1, 1993, and then again on October 1, 1994. Other urban hospitals are also scheduled for a formula increase effective October 1, 1993. Also, in late 1991 Congress approved a compromise between HCFA and state governments over state Medicaid financing arrangements. As part of that compromise, payments to disproportionate share hospitals between 1992 and 1995 cannot exceed 12 percent of the state's Medicaid expenditures. Payment fluctuations may result from these legislative and regulatory changes.

Prospective Payment System Matters

Amendments to the Medicare Prospective Payment System (PPS) can sometimes affect recorded revenues, receivables, and deferred amounts established to account for Medicare/Medicaid timing differences. In the September 1, 1992, *Federal Register,* HCFA issued final fiscal year 1993 changes for the Medicare PPS (57 F.R. 39746), which include provisions on PPS rates, ICD-9-CM coding, wage indexes, outlier payments, and rural referral status, among other matters. In the final regulations, HCFA provides a fiscal year-1993 PPS rate increase of 2.55 percent for urban hospitals and a 3.55 percent increase for hospitals in rural areas. These increases took effect on October 1, 1992.

Geographic Reclassification

Geographic reclassifications are used by HCFA to determine which hospitals are eligible for higher prospective payment rates. In 1992, the Medicare Geographic Classification Review Board approved the reclassification of 1,154 hospitals for federal fiscal year 1993. Each reclassified hospital's new prospective payment rate became effective October 1, 1992, and is valid for one year only. For federal fiscal year 1994, however, HCFA has issued regulatory changes that would make reclassification much more

difficult to obtain. These changes were published in the September 1, 1992 *Federal Register* (57 F.R. 39746). HCFA estimates that 70 percent of hospitals previously reclassified for wage index purposes will not qualify under the new criteria. This change in policy may result in reduced payments in future periods and may also affect future marginal debt-service calculations.

Audit Issues and Developments

Entities That Receive Governmental Funds

General. Auditors frequently are engaged to audit the financial statements of health care entities that accept financial assistance (other than Medicare and Medicaid) from federal government agencies. In performing such audits, auditors may be required to adhere to auditing standards issued by the General Accounting Office (GAO) (*Government Auditing Standards*, often referred to as the Yellow Book), by the Office of Management and Budget (OMB) (OMB Circular A-128, *Audits of State and Local Governments*, or OMB Circular A-133, *Audits of Institutions of Higher Education and Other Nonprofit Institutions*), as well as to generally accepted auditing standards issued by the AICPA. Auditors who encounter these additional audit requirements should carefully consider the impact of the additional requirements on the scope of the audit.

Auditors of health care providers that receive federal awards should consider the applicability of Statement on Auditing Standards (SAS) No. 68, *Compliance Auditing Applicable to Governmental Entities and Other Recipients of Governmental Financial Assistance*, to their audits. SAS No. 68 was issued in December 1991, and superseded SAS No. 63, *Compliance Auditing Applicable to Governmental Entities and Other Recipients of Governmental Financial Assistance*. Among other things, SAS No. 68—

- Provides guidance on the auditor's responsibility to report on the internal control structure in audits conducted in accordance with *Government Auditing Standards*.
- Reflects recent changes in federal audit rules and clarifies certain implementation issues.
- Provides guidance on the auditor's compliance auditing responsibilities under OMB Circular A-133.

SAS No. 68 is effective for audits of financial statements for periods ending after June 15, 1992.

In August 1991, the AICPA released an exposure draft of a proposed Statement of Position (SOP), *Audits of Not-for-Profit Organizations Receiving Federal Awards*. Release of a final statement is expected in late 1992. In

addition, SOP 92-7, *Audits of State and Local Governmental Entities Receiving Federal Financial Assistance,* was issued in September 1992. These documents summarize the various GAO, OMB, and Single Audit Act audit requirements with which affected health care organizations must comply.

When an audit is conducted under the requirements of *Government Auditing Standards,* certain additional continuing professional education (CPE) requirements apply to all supervisory personnel and most staff on the engagement. A detailed interpretation of the CPE requirements, *Interpretation of Continuing Education and Training Requirements,* is available from the U.S. Government Printing Office (Order number 020-000-00250-6). During engagement planning, auditors should ensure that appropriate members of the audit team have met the CPE requirements. The Yellow Book also requires audit organizations to have internal quality control systems in place and to participate in external quality review programs.

Federal government publications referred to above may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20401 (order-desk telephone: 202-783-3238; Fax: 202-512-2250).

OMB Circular A-133

In October 1991, the OMB issued *Compliance Supplement for Audits of Institutions of Higher Learning and Other Non-Profit Institutions,* which outlines the major compliance requirements that should be considered when performing an A-133 audit. Copies of the supplement can be ordered by contacting the U.S. Government Printing Office.

In May 1992, the President's Council on Integrity and Efficiency (PCIE), the government organization charged with administering the Single Audit Act of 1984, issued PCIE Position Statement No. 6, *Questions and Answers on OMB Circular A-133.* The Statement provides clarification and guidance relating to audits performed under Circular A-133. Among other things, the draft statement defines the term "hospital" for A-133 purposes, specifies the circumstances under which Medicaid funds would be included under A-133 audits, and clarifies the situations in which hospitals are considered to be "affiliated with an institution of higher education." Generally, minus any other criteria that would point to affiliation (as set forth in the implementing regulations), the presence of an affiliation agreement that does not result in hospitals' benefiting from the receipt of federally financed research and training funds would not require application of A-133 standards. In effect, this limits the applicability of A-133 to the federally financed research and training programs of hospitals that are affiliated with institutions of higher learning. PCIE Standards can be obtained by writing or faxing the Treasury Office of Inspector General, Room 7210, ICC Building, 1201 Constitution Avenue NW, Washington, D.C. 20220 (Fax: 202-927-5418 or 202-927-6492).

Use of Information in Offering Documents

Health care providers often issue debt securities, many of which provide tax-exempt income to holders, as a primary means of raising capital. For many years, auditors have issued letters to underwriters (comfort letters) in connection with securities offerings registered under the Securities Act of 1933 (the Act). Comfort letters are prepared in accordance with SAS No. 49, *Letters to Underwriters.* Comfort letters provide assistance to underwriters in connection with their statutory responsibilities under the Act. In recent years, auditors have been requested to issue comfort letters to lenders and others who are not underwriters.

In May 1991, the AICPA's Auditing Standards Board issued an exposure draft of a proposed SAS, *Letters to Underwriters in Conjunction with Filings Under the Securities Act of 1933 and Letters Issued to a Requesting Party in Conjunction With Other Financing Transactions.* A final SAS, expected to be issued in early 1993, would broaden the availability of comfort letters to a broker-dealer or other financial intermediary acting as principal or agent in an offering or placement of securities as long as they provide the accountant with certain written representations. The final SAS would also require the accountant to perform a review of interim financial statements, as described in SAS No. 71, *Interim Financial Information,* to provide negative assurance on interim financial information.

Feasibility Studies and Prospective Financial Information

CPAs are often asked to perform feasibility studies or to report on prospective financial statements for health care entities. Risk factors and applicable standards that accountants should carefully consider in deciding whether to accept such engagements are discussed in the "Notice To Readers On Prospective Financial Information," which was printed in the July 1991 issue of the *CPA Letter.*

In February 1992, the AICPA issued SOP 92-2, *Questions and Answers on the Term "Reasonably Objective Basis" and Other Issues Affecting Prospective Financial Statements.* The SOP supplements the guidance contained in the AICPA's *Guide for Prospective Financial Statements.* The presentation guidelines contained in the SOP are effective for prospective financial information prepared on or after August 31, 1992. The guidance on accountants' services is effective for engagements in which the date of completion of the accountants' services on prospective financial information is August 31, 1992, or later.

Debt Coverage

Many hospitals' debt-coverage indicators have continued to show unfavorable trends as their operating profits have eroded. Increasing reliance on

long-term debt, lower debt-service coverage ratios, and weakening financial performance may signal potential problems for many institutions. Declining profit margins in recent years have not allowed many providers to generate the capital needed to address their facilities' needs. Increasing reliance on debt financing at a time of weakening financial performance is an unfavorable trend that may create problems for many providers. These factors may influence the auditor's assessment of audit risk and may affect the ability of an entity to continue as a going concern.

Declining profit margins and strained financial conditions may also cause some hospitals to fail to be in compliance with their debt covenants. Consequently, some lenders may exercise demand clauses, decline to waive covenant violations, or refuse to renew short-term or letters of credit underlying debt. In some cases, hospitals may find it difficult to renegotiate favorable debt terms with lenders because of their current financial problems. They may be forced to seek alternative financing techniques that result in off-balance-sheet financing (that is, selling patient accounts receivable). In their haste to obtain capital through sources such as joint ventures, hospitals may also fail to consider transfer restrictions in their debt agreements that prohibit or limit the hospital's ability to transfer cash or property without permission from the lender or insurer. In such situations, auditors should consider the hospital's classification of its liabilities, the adequacy of its financial statement disclosures, and management's plans for obtaining alternate financing or disposing of assets.

In addition to consideration of failure to meet bond covenants, auditors should consider whether management has used bond proceeds in accordance with the provisions of the bond agreements, including those provisions that address investment policies. When hospitals or not-for-profit entities make investments and the ultimate yield exceeds the cost of borrowing, they may be subject to an arbitrage rebate liability. In such circumstances, auditors should satisfy themselves that management has performed appropriate calculations and, if appropriate, made an accrual.

Insurance Companies

Providers of health care services often have significant receivables from insurance companies that provide health insurance coverage to their patients. Providers also rely on insurance companies to underwrite their malpractice insurance coverage and to hold their pension assets. In addition, guaranteed investment contracts with insurance companies have become a popular means of investing crossover debt proceeds and pension assets. In light of the above, the financial difficulties being experienced by many insurance companies may have a significant impact on health care providers with which they do business. In evaluating audit risk relating to these factors, auditors should consider whether management has procedures for selecting and monitoring insurers. Auditors should also consider

obtaining appropriate information about the financial stability of insurers from which significant amounts are receivable or that provide significant coverage to the entity. The Department of Insurance in the state in which the insurance company is domiciled (or, in the case of separate operating subsidiaries, the state in which the entity is operating) may be able to identify insurance companies experiencing financial difficulties. Other sources available to assist in the evaluation of insurance companies include Best's Insurance Reports (908-439-2200), Veribanc (800-442-2657), Standard & Poor's Ratings Information Department (212-208-1527), and Moody's Investor Service (212-553-0533).

New GAAP Hierarchy

In January 1992, the AICPA's Auditing Standards Board issued SAS No. 69, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report.* The SAS establishes two separate but parallel generally accepted accounting principles (GAAP) hierarchies, one for state and local governmental entities (including governmental health care providers) and one for nongovernmental entities. Governmental providers operated as enterprise funds (that is, those that follow the principles in the AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services*) are subject to statements and interpretations of the Governmental Accounting Standards Board (GASB), AICPA, and Financial Accounting Standards Board (FASB) specifically made applicable to state and local governmental entities by GASB statements or interpretations. Therefore, when financial statements are prepared for a governmental health care entity that uses enterprise fund accounting and reporting, disclosure requirements set forth by GASB pronouncements and the AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services* apply.

Managed-Care Contracts

Both multispecialty and family-practice physician groups (as well as hospitals) frequently enter into managed-care contracts with HMOs that obligate them to perform all physician services for a specific number of enrolled patients at a fixed capitation rate. The groups assume the obligation to contract and pay for any services that the group itself is unable to perform. These contracts may also be subject to shared-risk arrangements in which the groups share in savings or are obliged to pay for cost overages that deviate from those actuarially predicted for enrolled patients. The risks assumed by groups in these arrangements may be subject to individual or aggregate stop-loss arrangements.

Since physician groups typically maintain their records using the cash or other comprehensive basis of accounting, their internal financial statements

may fail to include material liabilities for physician services authorized and performed under managed-care contracts. SOP 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services,* discusses managed-care contracts and is included as an appendix to the AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services.*

Related Parties

Certain relationships between health care providers and joint ventures, physicians, and other entities may result in the creation of related parties, as defined in FASB Statement of Financial Accounting Standards No. 57, *Related Party Disclosures.* SAS No. 45, *Omnibus Statement on Auditing Standards—1983,* provides guidance on procedures that auditors should consider to identify related party relationships and transactions and to satisfy themselves concerning the required financial statement accounting for and disclosure of transactions with related parties.

Accounting Developments

Combined or Consolidated Financial Statements

In June 1991, the GASB issued GASB Statement No. 14, *The Financial Reporting Entity.* This statement established standards for defining and reporting on the governmental financial reporting entity; standards for reporting participation in joint ventures; and disclosure requirements regarding the entity's relationships with other entities, including entities that are jointly owned. GASB Statement No. 14 is applicable to the separately issued financial statements of governmental component units, which specifically include governmental health care providers. It should also be applied to such component units when they are included in a governmental reporting entity. GASB Statement No. 14 is effective for financial statements for the period beginning after December 15, 1992. The GASB plans to establish a separate project on reporting by finance-related organizations such as foundations.

Reimbursement Timing Differences

Since the inception of the PPS, hospitals have been reimbursed for services provided to Medicare patients based on inpatient capital-related costs (for example, depreciation, interest, rent). HCFA, the federal agency responsible for administering Medicare and Medicaid programs, recently issued final regulations regarding the payment of Medicare inpatient capital-related costs for PPS hospitals. The regulations require hospitals to phase in the federal rate per discharge over a ten-year transition period. Transition period methods of payment differ for high- and low-cost hospitals, depending on the relationship between the hospital-specific rate and the federal rate.

Questions pertaining to Medicare capital-related timing differences resulting from these regulations are frequently received by the AICPA's Technical Service. These questions, along with answers provided by the Technical Service, have been published in Section 6400 of the AICPA's *Technical Practice Aids*, which states that hospitals should schedule out existing deferred debits or credits resulting from reimbursement timing differences to determine how much will actually be received/payable under cost-based reimbursement and adjust the deferred amount to reflect those new amounts. Adjustments would be classified as ordinary or extraordinary in the income statement based on the reporting of the transaction that gives rise to the original timing difference.

Certain matters pertaining to reimbursement timing differences are also in litigation. Most notably, many providers who have refinanced debt and incurred an accounting loss for the transaction have claimed reimbursement for the entire loss in the year the transaction occurred, consistent with GAAP used for external financial reporting purposes. Medicare intermediaries have not followed GAAP in this regard, and have allowed reimbursement of the loss in any given year only to the extent of the original debt's unamortized issuance costs. The outcome of this litigation may affect the value of timing differences carried as deferred assets or, in some cases, already written off by hospitals.

FASB Statement No. 105 Requirements

Auditors should be alert to the fact that the disclosure requirements of FASB Statement No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk*, may apply to health care providers' accounts receivable. Geographic concentration of credit risk is often an issue for health care providers because they generally tend to treat patients from their local or surrounding communities. In addition, guarantees on loans to physicians or related parties, and sales of accounts receivable with recourse, may represent off-balance-sheet risk for providers.

Governmental Reporting Requirements—Risk Financing

GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, provides guidance on accounting and reporting on governmental risk management and insurance activities. It requires governmental entities to report expenditures/expenses and liabilities for risks of loss that they elect not to insure when it is probable that a loss exists and the amount of the loss can be reasonably estimated. For governmental health care entities, the provisions of GASB Statement No. 10 are effective for financial statements for periods beginning June 15, 1994, with earlier application encouraged.

AICPA Audit and Accounting Literature

Audit and Accounting Guide

The AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services* is available through the AICPA's loose-leaf subscription services. In the loose-leaf service, conforming changes (those necessitated by the issuance of new authoritative pronouncements) and other minor changes that do not require due process are incorporated periodically. Paperback editions of the guides as they appear in the service are printed annually.

Health Care Financial Reporting Checklist

The AICPA's Technical Information Service has published a revised version of *Checklists and Illustrative Financial Statements for Health Care Providers* as a tool for preparers and reviewers of financial statements of health care entities. Copies may be obtained by calling the AICPA Order Department and asking for document number 008590.

Technical Practice Aids Publication

Technical Practice Aids is an AICPA publication that, among other things, contains questions received by the AICPA's Technical Information Service on various subjects and the service's responses to those questions. Section 6400 of *Technical Practice Aids* contains questions and answers specifically pertaining to health care entities. *Technical Practice Aids* is available both as a subscription service and in hardback form. Order information may be obtained from the AICPA Order Department.

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This Audit Risk Alert supersedes *Health Care Industry Developments—1991.*

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Auditors should also be aware of the economic, regulatory, and professional developments that may affect the audits they perform as described in *Audit Risk Alert—1992,* which was printed in the November 1992 issue of the *CPA Letter.*

Copies of AICPA publications may be obtained by calling the AICPA Order Department at (800) 862-4272. Copies of FASB publications may be obtained directly from the FASB by calling the FASB Order Department at (203) 847-0700, ext. 10.